Military Leader Perspectives of Psychological Fitness

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ABSTRACT

This paper reports on a sub-section of The Military Leaders Survey: NATO Military Leaders' Perspectives on Psychological Support in Operations. It specifically addresses the issue of psychological fitness, which in terms of the survey questionnaire relates to the sections on pre, during, and post-deployment. It was found that in most stages of the deployment cycle education and training to assist in psychological fitness was available to varying degrees for unit members. However, specific support for unit leaders was less prevalent. Assessment of unit readiness was utilised by a number of nations, particularly at the pre-deployment stage. The Commanding Officer, working in close conjunction with a psychologist, was seen as the key person for assuming responsibility regarding preparing military personnel for operational psychological readiness. Recommendations for further improving mechanisms included the provision of specific, practical, relevant information, particularly targeted at military leaders, and the need to work more closely with an informed and integrated mental health service.

Disclaimer: It should noted that the views of the authors do not necessarily represent their respective Department of Defence or Government.

1.0 INTRODUCTION

The main aim of the NATO HFM-081 RTO Task Group (RTG) on 'Stress and Psychological Support in Modern Military Operations' is to provide military leaders with information and practical guidelines (in the form of a booklet) on stress and psychological support in order to enhance effectiveness in modern military operations. In order to gather informed opinion as to the appropriate contents of such a booklet military leaders were consulted by means of a survey. This task was undertaken by the Military Leaders Survey (MLS) subgroup which consisted of several HFM-081/RTG group members.

Sixteen NATO nations (comprising 172 military leaders) were surveyed by means of either face-to-face interviews or postal survey, between June 2005 and February 2006. Respondents ranged in rank from Sergeant to Colonel and ideally had some operational command experience in the last 2 years.

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One of the booklet chapters is devoted to issues of mission psychological fitness (readiness) which relate directly to some of the questions used in the survey. Psychological fitness can be defined as 'The mental readiness to confront the challenges of deployment, whether combat, humanitarian, peacekeeping, or a combination of all three. Psychological fitness is the mental hardiness, resilience and mental toughness to face rigors of missions ranging from boredom to threat'. Psychological fitness is seen as both an individual and an organisational responsibility. Military leaders play a critical role in enhancing and maintaining the psychological readiness of their unit by providing the best training and sustaining motivation and morale. However, they are not alone in this task as they often work in conjunction with other professionals such as mental health services. Another crucial aspect of psychological fitness relates to unit assessment, which is generally in the form of screening and/or surveillance. Screening is a formal assessment process that is designed to determine whether or not the individual is in need of follow-up mental health services. Surveillance determines the psychological fitness of a group of personnel, generally by means of survey instruments. It is particularly useful for anticipating resource requirements, e.g. additional psychiatric support.

For the purposes of this paper the questions which relate specifically to psychological fitness are included in the questionnaire sections on pre, during, and post-deployment and one in the general section. The findings relate to the relevant questions which contain an element of psychological fitness (e.g. training, education, assessment, etc). The paper also sets out to identify relevant themes that bridge across at least two participating NATO nations rather than highlighting specific national issues. The sampling strategy used in this survey was a stratified convenience sample. Thus the sample provides general information that serves as a needs assessment regarding the issue of military leader attitudes toward psychological support on operations.

2.0 FINDINGS

2.1 Pre-deployment psychological fitness

2.1.1 Psychological preparation received by the unit prior to the last deployment in order to cope with any psychological or stress-related problems that might occur during the operation/mission.

One of the major contributing factors to enhanced psychological fitness prior to deployment is the range of education and training given to both the units and the military leaders. In terms of unit fitness there was some variability within nations as to whether they received pre-deployment stress-related training. For instance, at least one individual from every nation reported some pre-deployment unit briefing, group instruction, or education, whilst respondents from nine nations reported that their units received no pre-deployment preparation.

Briefings or education were the most typical type of pre-deployment stress-related preparation, though respondents from five nations mentioned having training exercises that incorporated dealing with psychological stress in some fashion. Respondents from three nations also reported having had formal meetings with military personnel who had previous deployment experience.

Pre-deployment training and education topics included the psychological stages of deployment, normalizing responses and reassuring unit members about their own reactions, identifying suicidal risk factors, dealing with family issues, and teaching about combat stress. Respondents from four nations also reported receiving booklets and other materials on these topics and respondents from at least two nations reported accessing web-site material as well.

Assessment of unit readiness is a developing tool being adopted by a number of NATO nations in a bid to enhance psychological fitness. Respondents from eight nations described unit members being interviewed

individually by a mental health professional prior to their deployment. These interviews attempted to identify those individuals in need of support from a mental health professional and also provided commanders with an objective assessment of unit readiness.

2.1.2 Specific training or preparation received by the unit leader for supporting subordinates in the event of encountering stress-related problems during the operation/mission?

Respondents from 15 of the 16 nations surveyed reported receiving no training specifically geared toward preparing military leaders to handle stress-related problems in their unit. When training was mentioned it was a mix of formal and informal mechanisms, and of varying technical complexity, e.g. a quick basic briefing compared to a 4 day course.

Respondents from eight nations reported participating in some kind of staff course or military academy course in which stress-related topics were covered. Three respondents from three nations reported that university courses helped to prepare them as military leaders for dealing with the stress-related problems experienced by their unit. Another type of formal training included briefing and instructions as reported by individuals from seven nations.

Of those respondents who reported receiving training, the training was sometimes general rather than specific to the upcoming deployment. For example, one respondent commented, “Nothing received specific to that deployment”. Others commented that there was nothing specifically designed for military leaders and they “just took part in education for all the unit.” A further respondent mentioned, there was “no training geared towards senior leadership.” Particular topics covered included bereavement classes, sharing bad news, conflict management, trauma reactions, locating resources, and stress management/ prevention.

In terms of informal mechanisms of support, respondents from five nations reported that they relied on their own deployment experience. As one leader mentioned, he received “nothing formal but experience…was good preparation. We had regular small team talks (on the previous deployment) and that’s what we continued to do (on the next one).” Respondents from two nations reported talking with others who had similar deployment experiences.

2.1.3 Aspects of psychological preparation provided pre-deployment that need changing and/or improving upon?

Recommendations made about how pre-deployment psychological preparation could be improved upon included:

- Be Specific: Respondents were consistent in their recommendation that the training be oriented toward specific, practical information and based on case examples. As one respondent commented, “case-based, specific and concrete education” was preferred. Recommendations included providing “useful tips”, being “taught specific tools for handling stress”, and “examples, real situations, and practical advice.” It was also suggested that this guidance be provided in some kind of written material, such as a pocket card with highly detailed information.
- Educational Content: There was a range of topics suggested for inclusion in a pre-deployment stress preparation program, which included a focus on psychological responses to stress such as traumatic stress, combat stress, and stress symptom recognition. Recommendations included “more information on PTSD, such as signs and symptoms, actions needed, self help, etc.” Another respondent mentioned wanting “more information about physiological effects of, and reactions to, stress.”
- There were also recommendations to normalize the stress associated with deployment, align expectations, and use film or examples to prepare individuals for the psychological realities.

There were several comments about the need to train units to deal with death, including "dealing with friendly fire fatalities and injuries," "mission casualties," and "lectures on death (e.g. what to do, follow-up and help for the platoon)."

- Past experience: A few respondents recommended using leaders from previous deployments to help train new leaders. Some benefit was also seen in having former leaders explain what to expect, and provide real life case examples.
- Mental Health Professionals: Respondents commented that mental health professionals need to be available and integrated into the unit. Comments included, "I'd like professional advice on call, at hand to deal with individual cases. Someone who was able, physically, to go out to the unit and help." Another commented, mental health professionals should "help leaders know what to look for and have them trust mental health professionals." They should "integrate a military mental health professional in the normal training and education process, this builds trust."
- Target leaders: Several respondents commented that unit leaders should also receive special training as they often have to be first in dealing with situations. For example, one recommended "a session with the leaders of the specific deployment, including a discussion of guidelines or best-practices towards handling incidents."

2.2 Psychological readiness during deployment

2.2.1 Psychological support received by unit during the last deployment in order to cope with psychological or stress-related problems that might occur during the operation/mission?

Eleven nations consistently reported receiving several different kinds of deployment support. Mental health support was provided by a wide range of specialists including social workers, psychiatric nurses, psychologists, chaplains, and medical professionals. Many nations also mentioned relying on buddies for support.

Respondents reported that support occurred both formally and informally. Examples of informal support included R&R, mutual support, advice from those with previous operational experience, and specialists who stop by and check in with various units across a geographically dispersed area. Examples of formal support included advice from mental health specialists, individual consultations with targeted sub-groups, and group debriefing/defusing sessions. These formal mechanisms were often in response to a specific traumatic event (helicopter crash, ambush with casualties, accident involving death of a soldier, etc.).

2.2.2 Specific support received by the unit leader for assisting unit members if they encountered stress-related problems during the operation/mission?

Military leaders from 10 nations said that they did not receive any specific support for assisting unit members, whilst 5 nations claimed to receiving only minimal support. In the few cases where support was offered, it was in the form of identifying individuals with mental health problems, addressing risk of suicidal behaviours, briefings, and support from friends. In general, the support was provided by other leaders, mental health professionals, and chaplains.

2.2.3 Aspects of psychological support provided during operations that need changing or improving upon?

Recommendations made by respondents from at least two countries (regardless of how satisfied the individual was with the support provided), included:

- Mental Health Professionals: Several recommendations related to the qualifications and approach of mental health professionals. For example, it was suggested that chaplains, who were considered an excellent source of support, should receive more formal training in mental health awareness.

- Other respondents recommended that mental health professionals be given adequate deployment training, increase their understanding of the military, the unit, command, etc, and adapt their support to the different phases of the mission. Similarly, it was recommended that mental health professionals adopt a pro-active role to being integrated with the units and task forces, possibly by being embedded with the unit or available on-site. Thus, in the event of a critical incident mental health support could be rapidly augmented.
- Leadership: Respondents recommended that leaders be provided with more direct support by mental health professionals, particularly given their isolation in decision-making when on deployment. It was also recommended that leaders be trained in what to look for and how to deal with stress in subordinates.
- Target problems: Respondents noted that many unit problems were related to home front issues, not just operational issues. Thus, mental health support needed to be able to handle these home front issues as well. Furthermore, it was recommended that certain issues be the focus of support by mental health professionals, including alcohol problems, specific operations, and/or sub-groups (e.g., transportation units which are not trained for combat). Respondents also thought that there should be regular/routine meetings between soldiers and/or leaders with mental health professionals.
- Some also recommended additional during-mission screening to identify those having problems. Finally, two types of training were recommended: communication training (e.g., to integrate new members into unit), and peer training (to provide mental health support during deployment).

2.3 Psychological readiness post-deployment

2.3.1 Psychological support received by the unit after the last deployment in order to cope with psychological or stress-related problems that might occur after the operation/mission?

The majority of nations reported some type of formal psychological support related to returning from deployment. This support included a wide array of mechanisms: individual interviews with military mental health professionals, briefs on homecoming, debriefing, surveys/screening, and some period of time set aside for decompression. Only a handful of nations reported having had a homecoming program that integrated such support mechanisms as decompression and interviews, or briefings and surveys.

Several respondents commented on the need to extend support to families by including them in the briefings and providing them with information leaflets, etc. As one respondent said, the spouses “will be the ones to notice radical changes in behaviour, such as not sleeping, etc.”

Some respondents reflected on the need to consider the duration of the post-deployment support. For instance, reintegration should be gradual, that individuals should not be immediately dispersed to home units, that support should occur over a period of time and include follow-up (e.g., 3-6 months after returning home).

2.3.2 Specific support received by the military leader for assisting unit members with stress-related problems following the operation/mission?

Respondents from 15 of the 16 nations reported that there was no specific training for leaders to manage the psychological stress of unit personnel post-deployment. Besides the one nation that had such training, approximately 6 respondents from other nations reported receiving some form of briefing about post-deployment stress (e.g., suicide, the signs and symptoms of post-traumatic stress disorder) that was geared for leaders.

There was general agreement that military leaders were the first line of defence for identifying mental health problems in unit personnel (e.g., “It is down to the unit leader to make the first assessment”), but

when individuals were augmentees or otherwise dispersed, providing this support was often very difficult. Others described maintaining an informal network, or knowing who to contact in the event a unit member had a psychological problem post-deployment.

2.3.3 Aspects of the psychological support provided post-deployment that need to be changed or improved upon?

Recommendations about ways in which psychological support could be improved post-deployment included:

- Unit integrity. Maintaining unit integrity for a period of time at post-deployment was an important issue for respondents from at least four nations. For example, respondents from several nations described that shortly after homecoming, individual unit members were dispersed across other units. Maintaining unit integrity was noted as both facilitating the adaptation back home, ensuring military personnel had friends to talk with, and enabling leaders to assess the adjustment of their unit members more easily. Respondents suggested that unit integrity be maintained for at least three months.
- One respondent noted "Currently, when a unit returns home some personnel are immediately despatched to another unit. This means they have no-one to talk to about the highs and lows relating to their recent operation. You need 3 months together as a unit during and post-deployment."
- Duration/Timing of post-deployment support. Respondents from 7 nations suggested that psychological support be extended beyond the immediate post-deployment period and be provided from at least 3 to 6 months post-deployment. Respondents from the nation that specifically instituted such follow-up perceived benefits associated with this approach.
- One respondent said, "A follow-up interview at the three month stage would improve the psychological support after a mission." An individual from another nation commented that "There is a need for psychological consultations after the deployment; however, it must start at least a week later."
- Developing an organized decompression phase. This recommendation included slowing the return home. Respondents commented on the need for decompression time prior to reintegration (e.g., "one moment we were in the desert and the next we were … on the way home" and another spoke of the need "to relax with the first beer without the home front"). Another recommended the military "extend the acclimatization period."
- Information. Several respondents recommended providing information (booklet, brief, etc.) on post-deployment psychological adjustment. The information should be targeted at the family members (i.e. spouse) and detail signs and symptoms of stress-related problems. The information should also include an easy way of listing information on local mental health resources. One respondent suggested including information on spouse abuse.

  Some respondents mentioned the need to provide specific consultation to leaders, to train them before the deployment to recognize and deal with stress reactions, and to provide additional individual support to the leadership. As one respondent recommended, "talk to leaders and see how they are doing as it is pretty stressful for NCOs and Officers."

- Interviews. Respondents from several nations recommended structured individual interviews with military personnel and commanders. Respondents from several nations that did not do this routinely suggested that this would be particularly helpful for deployments that were especially stressful or dangerous. Several respondents mentioned the importance of face-to-face interviews rather than relying on a survey alone.

- Visibility of mental health professionals. Respondents from several nations suggested that military mental health professionals be available (e.g. standing by, meeting with unit members) during homecoming and after. As one respondent noted, "Optimally, psychologists could be standing by at base to assist if necessary during the homecoming procedure." Having someone assigned to a unit was not enough, respondents commented that military mental health professionals need to make themselves visible and accessible. Having deployment experience, and understanding the military were also considered critical for maintaining credibility and being helpful to returning military personnel.
- Informal Support Networks. Several respondents from several nations mentioned the importance of informal support networks in helping individuals cope with stress during the post-deployment phase. Respondents recommended that these informal support networks be supported by maintaining unit integrity (see above), making individuals aware of these networks and facilitating the creation of these networks following the return home. Respondents also recommended using these networks as an additional way to assess the well-being of individuals and to integrate mental health support in these networks. For example, a couple of respondents recommended that mental health professionals be present during social gatherings.

2.4 General questions

2.4.1 Which personnel should be responsible for preparing military personnel for operational psychological fitness.

Commanding Officer (CO): Respondents from across 8 nations stated that the CO should be responsible. The reasons given included that the CO bears ultimate responsibility and they have the necessary experience and knowledge of the military to know the needs of the individual and the organisation as a whole, in order to make informed decisions and co-ordinate the mission. Frequent reference was made to the close proximity and daily contact that COs have with their subordinates which in turn aids good leadership. However, many respondents also recognised the need for professional mental health workers when appropriate to support them in bringing about operational psychological readiness.

Psychologist: The second most common response to the question of who is responsible for preparing military personnel for operational psychological readiness was a psychologist (6 nations). Psychologists were seen as specially trained people who had the necessary in-depth knowledge and experience relevant to this area and were often referred to as experts. Many of the NATO nations have uniformed psychologists so there was often an accepted mixture of both professional and military expertise. Wearing a uniform also meant the psychologist could be deployed with the unit which added to their kudos and aided their acceptance within the unit.

Medical staff: Approximately 20 respondents put down Medical Staff as their first choice, though hardly any stipulated a medical specialist such as a psychiatrist. Whilst a number of respondents qualified their choice with such statements as "being specially trained to deal with stress", "being the best person for the job", or "having the authority and facilities to undertake the role", the majority did not give a reason for selecting a Medical Officer.

Options receiving 10 or less responses included: the chaplain (compassionate, good interpersonal skills, and knows the troops); military personnel themselves (should take responsibility for their own welfare, need to develop own skills and systems, can apply lessons learned); personnel and welfare staff (have appropriate training); and to a lesser extent, peers, the General Staff, military educational establishments, and the Government.

In summary, respondents indicated that the CO should have the main responsibility, followed by the Psychologist, and to a lesser extent Medical Staff, but also that the best option was for the CO and

Psychologist to work in close collaboration. Seventy responses only gave one preference, whilst the rest mainly opted for 2-3 preferences.

3.0 CONCLUSIONS

In terms of pre-deployment psychological fitness, most nations reported having received some form of unit training and education, although there was some variability within nations. Training and education topics included normalizing responses and reassuring unit members about their own reactions, and teaching about combat stress. Formal assessment of psychological fitness was undertaken by a number of nations. There was however, very little in the way of specific training and education for unit leaders, many of which often relied on personal experience. Specific recommendations for improvement included the provision of specific, practical, relevant information, especially targeted at military leaders, and the need to work in conjunction with mental health professionals.

During deployment, unit psychological fitness support was provided by a number of sources, e.g. mental health professionals, social workers, chaplains, etc. Support was both informal (e.g. R&R, peer support) and formal (e.g. group debriefing). Support for military leaders in particular appears to have been generally non-existent or the bare minimum (e.g. basic advice on identifying individuals with stress-related problems). Specific recommendations for improvement centered around the need for well trained mental health professionals with deployment experience being embedded within the unit, in order to provide immediate psychological support.

In terms of post deployment, the majority of nations reported some type of formal unit psychological support including: individual interviews with military mental health professionals, briefs on homecoming, debriefing, surveys/screening, and some period of time set aside for decompression. Once again, there was no specific training given for military leaders to manage the psychological stress of unit personnel. Specific recommendations for improvement included: maintaining unit integrity, extending the decompression phase and the increased visibility of mental health professionals.

With regard to which personnel should be responsible for preparing military personnel for operational psychological readiness, the Commanding Officer (CO) was given prime position by virtue of them having ultimate responsibility, having the necessary knowledge and experience, and from constant close proximity to their subordinates. However, the role of the mental health professional, particularly that of the psychologist, was recognised, as was the need to utilise a joint approach towards operational psychological fitness.

Other sections of the Military Leaders Survey will be integrated with these findings in order to develop a comprehensive perspective of what military leaders think about mental health support. These sections, including unit climate assessment, support to families, and stigma associated with stress and seeking psychological support, serve as the basis from which the NATO HFM-081 RTG can develop recommendations for best practice, future work, and a military leaders handbook on psychological stress on modern military operations.